Bureau of Health Care Quality & Compliance

9/2/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS641HOS	A. BUILDING _____ B. WING _____	05/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS HOSPITAL	2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119

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S 000	Initial Comments This Statement of Deficiencies was generated as the result of a complaint investigation survey conducted at your facility on 04/30/09 and 05/01/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. The following nine complaints were investigated. Complaint # 21697 - Unsubstantiated Complaint # 21003 - Unsubstantiated Complaint # 21727 - Unsubstantiated Complaint # 21745 - Unsubstantiated Complaint # 18051 - Substantiated (Tag # S0143, S0322) Complaint # 21515 - Substantiated (Tag # S0297, S0298) Complaint # 18985 - Substantiated (Tag # S0310) Complaint # 21612 - Substantiated (Tag # S0335) Complaint # 21277 - Substantiated without deficiencies The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified.	S 000		
S 143 SS=D	NAC 449.332 Discharge Planning 1. A hospital shall: (a) Have a process for discharge planning that applies to all inpatients; and (b) Develop and carry out policies and	S 143		

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Sam Kaplan TITLE CEO (X6) DATE 6/22/09

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S 143	Continued From page 1 procedures regarding the process for discharge planning. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to carry out policies and procedures to ensure the safe discharge of a patient. (Patient #3) Finding Include: On 04/21/08 a report from the Division of Aging Services indicated Patient #3 was discharged from the facility on 04/18/08, with a Foley catheter in place and no physician discharge instructions for Foley catheter care or home health care. The patient was discharged home by ambulance with no clothing or belongings and wrapped only in a blanket. A Discharge Summary dated 05/07/08, indicated the patient was a 94 year old female who was admitted to the hospital on 04/17/08 because of acute GI (gastrointestinal) bleed with blood loss and anemia. The patient was transfused with 2 units of blood and had an EGD (esophagogastroduodenoscopy) procedure which revealed multiple gastric ulcers. The patient was placed on a protein pump drip post procedure. The patient was hemodynamically stable and was discharged on 04/18/08, with Protonix medication to take twice a day. The Emergency Room Nursing record dated 04/17/08, indicated the patient was brought to the emergency room by ambulance from home. The patient was triaged in the emergency room at 6:37 AM. The patient had a Foley catheter inserted on 04/17/08 at 10:45 AM. The patient was disrobed a 6:45 AM and placed in a gown.	S 143	**Tag S 143** The identified patient had been discharged prior to the survey and it is not possible to address this particular patient. All patients admitted to the facility have the potential to be affected by this practice. The facility policy *"Nurses Discharge Notes and Instructions"* was reviewed, no revisions were required. The Director/Manager of the unit involved with this individual patient has reviewed the policies and procedures related to discharge planning with her clinical staff. The Unit Director has also discussed with her staff the need for documentation of discharge instructions, discharge assessment, and medication reconciliation. Additionally, all clinical Directors/Managers have reviewed these policies and procedures with their staff. No individual counseling was completed as the employee involved in this patient's care is no longer employed at the facility. **Individual responsible: Directors/Managers of Nursing Units** **Date of Completion: 6/30/09**	

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S 143	Continued From page 2 A Nursing Admission Assessment dated 04/17/08, documented under Genitourinary that the patient had a Foley catheter in place. A Case Management Initial Assessment Form dated 04/18/08, indicated the patient had a Foley catheter, IV (intravenous line) and oxygen. The anticipated discharge plan included home health, occupational therapy, physical therapy and CNA (certified nursing assistant). A note indicated the patient would be followed by a case manager. A facility Exit Care Patient Information form dated 04/18/08 at 7:30 PM, revealed the only discharge instruction documented on the form was for the patient to follow-up with her primary care physician in 1 week. A Physician Progress Note dated 04/18/08, indicated the patient was seen and the hemoglobin and hematocrit were stable. "The patient was stable for discharge home today." A Physicians Order dated 04/18/08, documented the following: 1. "D/C (discharge) today." 2. "Appointment with primary care physician in one week." 3. "Patient needs transport home, inform Case Manager." A Nursing Note dated 04/18/08 at 7:30 PM, indicated the patient was discharged home via a medi coach via a stretcher. On 04/30/09 at 8:00 AM, a review of the medical record indicated there was no documentation in the nursing notes that the patients Foley catheter was discontinued by nursing staff prior to the	S 143		

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S 143	Continued From page 3 patients discharge. There was no documentation of a physicians order for the patient to be discharged home with a Foley catheter in place. On 05/01/09 at 8:30 AM, the Performance Improvement Manager reviewed Patient #3's medical record and confirmed there was no documented evidence that nursing staff discontinued the patients Foley catheter prior to discharge. The Performance Improvement Manager indicated the nurses did not follow facility discharge policy and conduct a final assessment of the patient prior to discharge and discontinue the patients Foley catheter. A facility Nurses Discharge Notes and Instruction Policy dated 05/07, indicated under Procedure: Patient Instructions should include: a. A completed medication reconciliation. b. How to meet the needs for physical, emotional pain management. c. Available community resources. d. The nurse will document what the physician ordered for follow-up care. e. The nurse will instruct the patient on activity level, diet, equipment needed f. The nurse will check those items instructed to the patient. g. The nurse will document whether the patient verbalizes understanding of the instructions by checking the yes or no box. h. The nurse will document the valuables returned and personal belongings by checking the yes or no box. "The nurse will complete a final assessment on discharge and document such in this section." Severity: 2 Scope: 1	S 143		

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S 143	Continued From page 4 Complaint #NV00018051	S 143		
S 297 SS=G	NAC 449.361 Nursing Service 8. The chief administrative nurse shall define the policies, procedures and standards relating to the provision of nursing services and shall ensure that the members of the nursing staff carry out those policies, procedures and standards. The policies, procedures and standards must be documented and accessible to each member of the nursing staff in written or electronic form. The chief administrative nurse must approve each element of the policies, procedures and standards before the element may be used or put into effect. This Regulation is not met as evidenced by: Based on interview, record review and document review the chief nurse failed to ensure nursing staff carried out policies and procedures concerning the use of alcohol prep solutions and fire response policies. (Patient # 4) Finding include: A facility Physician Transfer Summary dated 03/21/09, indicated Patient #4 was a 90 year old female admitted to the facility with diagnoses including symptomatic bradycardia (low heart rate) hypertension and dementia. The patient was taken to the cardiac catheterization lab to have a pacemaker implantation. The pacemaker implantation was complicated by an intraoperative fire in the cath lab. The patient suffered significant facial and neck burns and was transferred to another Hospital's Intensive Care Burn Unit for treatment.	S 297	**Tag S 297** The identified patient had been transferred to another facility prior to the survey and it is not possible to address this individual patient. All patients admitted to the facility have the potential to be affected by this practice. The Chief Nurse Officer reviews and authorizes all policies, procedures and standards of care related to nursing care. The facility has access for all staff to the policies, procedures, and standards via the Valley Health System Internet website, with all staff having ready access to computers. Prior to the initiation of Intranet access to policies and procedures in 2008, staff was educated on the procedure for accessing this information. The facility has re-educated the clinical staff in the Cardiac Cath Lab related to the procedure for accessing the "Red Book" (Policy and Procedure).	

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S 297	Continued From page 5 On 04/30/09 at 9:00 AM, the Chief Nurse indicated on 03/22/09 at approximately 7:00 PM, Patient #4 was in the cardiac catheterization suite lab for placement of a permanent pacemaker. The Chief Nurse indicated a Chlora Prep alcohol based prep was used on the patient's skin and allowed to dry for 20 to 30 minutes prior to the procedure started. The patient was on high flow oxygen re-breather mask. When the surgeon activated the Bovie Knife there was an arch that was witnessed by the surgeon and staff present and the patients drape expanded and caught on fire. The cardiologist removed the patients drape. The fire was extinguished by the tech that used a bulb syringe with sterile water to extinguish the fire and a wet towel. The patient sustained second and third degree burns on her neck, face, chest, left shoulder and back. The emergency room physician was called and responded to the scene and assessed the patients airway and cleaned the patients burns. The patient was then transported to another facility's burn unit. The Chief Nurse did not recall if the fire department was notified. The incident was reported to the State Health Division on 03/26/09 at 11:30 AM. A Sentinel Event report was completed and submitted to the Nevada State Health Division by the facility on 04/07/09 at 12:30 PM. The Chief Nurse indicated the facility was looking at using non alcohol preps and revising the fire risk prevention procedure to include not allowing prep solution to pool under the patient and not draping the patient until the prep solution has dried. The Chief Nurse reported the facility's investigation indicated there were three factors that contributed to the incident. 1. The patient was on high flow oxygen with a re-breather mask. There was no oxygen tank in the cath lab. All oxygen was dispensed from an	S 297	All staff, including Cath Lab personnel are required to complete annual competencies, with the last annual competency completed in 2008 and due to be completed by July 1, 2009. These competencies include: 1. Infection Control 2. Handling Hazardous Materials 3. Electrical and Medical Device Safety 4. National Patient Safety Goals 5. Bloodbourne Pathogens 6. Emergency Preparedness 7. Understanding Tuberculosis 8. Understanding HIPAA 9. Healthcare Facility Security 10. Fire Safety 11. Body Mechanics The Director of the Operating Room and Directors/Managers of the Invasive Procedures units have reviewed and revised facility policies and procedures for prepping of patients and Surgical Skin Antisepsis to ensure that the practice meets the current AORN standards and those of current evidence based standards of care. All clinical staff are required to demonstrate current competency on these policies and procedures, this documentation is on file in Human Resources file.	

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S 297	Continued From page 6 oxygen wall outlet. 2. The facility used Chlora Prep which was alcohol based prep and highly flammable. The recommended drying time was 3 minutes. The staff allowed the prep to dry for 20 to 30 minutes prior to starting the procedure. 3. Chux pad placed under the patient to catch any drip from the prep were not removed prior to the procedure and residual alcohol based Chlora Prep still present on the Chux pad may have been a fuel source and a contributing factor to the fire. When the surgeon activated a cautery tool for hemostasis the drape covering the patient ignited burning the patient. On 04/30/09 at 11:00 AM, Employee #1 indicated she was responsible for applying the Chlora Prep to the patient prior to the placement of a permanent pacemaker battery procedure. Employee #1 indicated a thick blue Chux pad was placed under the patients head and shoulder area prior to the administration of the prep solution to the patient's chest. Employee #1 indicated a 26 ml (milliliter) Chlora prep was used on the patients chest. Employee #1 could not recall how much of the prep solution may have dripped onto the Chux pad under the patient. The Chux pad was not removed from under the patient following the administration of the prep solution. The patient had a non re-breathable oxygen mask on and oxygen was flowing to the mask. A drape was placed on the patient which covered her face, oxygen mask and head in a tent like fashion. Employee #1 indicated the prep had dried for 15 to 20 minutes prior to the start of the procedure. Employee #1 left the cath lab and was not present when the procedure started. Employee #1 heard the patient scream and	S 297	The facility reviewed the policy and procedure for fire response, no revisions required in policy. Cath Lab staff were re-educated on the fire response policy which includes calling a "*Code Red*". All employees are responsible for knowledge of facility policies and procedures and ensuring that their practice is consistent with those evidence based standards of care. The patient was on high flow oxygen via a non-rebreather mask. The procedure nurse inverted the oxygen mask to keep the oxygen bag out of the sterile field. This practice does not follow standards of care for high flow oxygen, hospital standards, or the manufacturer's instructions for use of the mask. Individual counseling of staff was completed related to placement of oxygen mask. The Director of Pulmonary Services along with clinical staff reviewed with the clinical staff the proper procedures for Oxygen Therapy in the Cardiac Cath Lab. The root causes identified for this incident include: 1. Concerns with proper functioning of equipment and oxygen delivery system. 2. Orientation and training in the Invasive Procedure areas did not address how to assess patients for a high risk of fire, or how to prevent fires in these cases.	

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S 297	Continued From page 7 looked through the cath lab window and saw the surgeon pulling off the patients drape which was on fire. When employee #1 entered the cath lab with two blankets she saw the patients chest smoldering and the drape was on fire on the floor. The surgical technician had thrown a bowel of sterile water on the patient and used a sterile wet towel to put out the fire. Employee #1 acknowledged no one called a 6666 code red (fire alarm). Employee #1 did not know if any staff member called the fire department. Employee #1 indicated the facility no longer placed Chux pad under the patients prior to using Chlora Prep. The facility now used a washcloth or towel and removed them when the prep was completed. On 04/30/09 at 1:00 PM, Employee #2 indicated prior to the placement of a permanent pacemaker battery procedure a Chux pad was placed under the patients head and shoulders and Chlora Prep was used to prep the patient's chest area. The patient was receiving 10 liters of oxygen via a non rebreathe mask. The Chux pad was left under the patient and the patient was then draped after the prep on the patient's chest had dried. Employee #2 indicated she saw the surgeon use cautery tool on the patients chest and saw the drape covering the patients head catch on fire. The surgeon removed the drape and the patient's chest was on fire. The fire was extinguished by the surgical technician who used a basin of sterile water to douse the flames. Employee #2 indicated she did not follow the facility's fire response plan and call a code red when the fire occurred. Employee #2 confirmed the fire department did not show up at the facility or conduct an investigation into the cause of the fire. Employee #2 indicated she had been working in the cath lab for 7 years as a scrub monitor and circulating nurse but had not been trained by the	S 297	The facility reported this incident to both the State of Nevada Sentinel Event site and to the Joint Commission. The Joint Commission conducted a special survey on May 28, 2009 and deemed that the Root Cause Analysis had been thorough and credible and that the associated action plan was appropriate and acceptable. **Individual responsible: Director of Surgical Services, Chief Nursing Officer, Director of Ancillary Services, Director of Pulmonary Services, Risk Manager, Performance Improvement Manager** **Date of Completion: 5/15/09** This employee's statement is false. Employee # 2 received orientation upon hire of hospital policies and procedures, including fire safety and also completes competencies annually with the most recent completion in 2008. Those competencies include fire safety, see page 12).	

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S 297	Continued From page 8 facility on the use of alcohol based preps or the potential risk of flammable vapors igniting and causing injury to a patient. A facility Incident Report dated 03/22/09 documented the following: "During the dissection of a pocket to place a permanent pacemaker battery, the surgeon used cautery for hemostasis. A fire ensued about the patient's head and neck. Fire was put out by surgeon immediately removing drapes, scrub technician doused fire with 800 cc sterile saline solution on fire and also used a bulb syringe to extinguish fire. Emergency room physician called to assess patient's airway which was not compromised. Family informed by CEO (Chief Executive Officer) and visited patient. Patient transferred to hospital burn ward." The Sentinel Even Report- Section II dated 04/07/09 at 12:30 PM, under Primary Contributing Factors indicated the following: "The incident was staff related/clinical performance/administration. The corrective action included equipment modification, policy review, procedure review, process review, situation analysis and staff education and training." Chlora Prep drug facts indicated the active ingredients consisted of Chlorhexidine Gluconate 2% (Antiseptic) and Isopropyl Alcohol 70% (Antiseptic) Warnings Included: "For external use only. Flammable, keep away from fire or flame. To reduce risks of fire: a. "Solution contains alcohol and gives off	S 297	**Tag S 297** All employees in Invasive Procedure areas received and reviewed "Important Information on Fire Safety with a signed attestation of their understanding of the principles of fire safety and the fire risk assessment. **Individuals responsible: Director of Surgical Services, Director of Ancillary Services, Risk Manager, Performance Improvement Manager** **Date of Completion: April 15, 2009** A. Development and implementation of fire risk screening tool, tool to be based on AORN standards. UHS Corporate developed a fire risk screening tool for all UHS facilities. 1. Electronic documentation of fire risk assessment in Cardiac Cath Lab formatted in the MAC Lab 2. Implemented use of paper tool used by other VHS facilities for fire risk assessment in those areas that don't have electronic documentation. 3. Corporate UHS developed a corporate-wide tool for risk assessment that was implemented in first week of June.	

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S 297	Continued From page 9 flammable vapors." b."Do not drape or use ignition source (cautery, laser) until solution is completely dry" (minimum of 3 minutes on hairless skin) c."Avoid getting solution into hairy areas. Solution may take much longer to dry completely." d."Do not allow solution to pool." e."Remove wet materials from prep area." Directions: 1. "To reduce the risk of fire the following strategies are recommended:" a. "At the end of the prep, discard any portion of the solution which is not required to cover the prep area." b. "Use in a well ventilated area." c. "Tuck prep towels to absorb solution, then remove." d. "Remove wet material from prep area." e. "Drape after solution is completely dry." The facility's Surgical Skin Prep Washing/Painting policy and procedure dated 08/06 included the following: 1. "Keep the prep solution from pooling beneath the patient and away from the electrosurgical patient electrode and tourniquets. Chemical burns may result if allowed to remain in contact with the skin." 2. "Sufficient time for complete evaporation of a flammable antimicrobial agent needs to occur before electrosurgical devices or lasers are used. Evaporation of flammable antimicrobial agents decreases the possibility of fire." "Open towel and pat dry the area dry to remove excess scrub solution. Remove the towels used	S 297	B. Educated all OR, Cath Lab, Special Procedures, and GI Lab staff regarding fire risk assessment. 1. Education packet 2. AORN Guidance Statement, Fire Prevention in the Operating Room 3. ECRI Surgical Primer, *"The Patient is on Fire"!* 4. *"The Fire Triangle"* 5. ECRI flyer, *"Only You can Prevent Surgical Fires"* **Individuals responsible: Director of Surgical Services, Director of Ancillary Services, Risk Manager, Performance Improvement Manager** **Date of Completion: June 30, 2009** C. Validate that all invasive procedure areas are completing a Fire Risk Assessment prior to procedure D. Creation of audit tool 1. Implementation of audit to validate that staff are completing and documenting the fire risk assessment and actions taken to reduce that risk 2. Perform audits to validate that staff are completing and documenting the fire risk assessment. 3. ECRI Guidance Article- *"Conducting a Safety Audit"*	

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S 297	Continued From page 10 to square off the field by lifting edges of the towel while paying close attention not to drag edges of towel across prepped field." The facility's AORN (Association of Peri Operative Registered Nurses) Fire Safety Tool Kit Policy last revised 1/05 included the following: 1."When an alcohol based solution is used, use minimum amount of the solution and allow sufficient time for fumes to dissipate before draping." 2."Observe drying time (minimum 3 minutes) do not drape patient until flammable prep is fully dry." 3."Do not allow pooling of any prep solution."(including under patient) 4."Remove bowls of volatile solution from sterile field as soon as possible after use." 5."Utilize standard draping procedure." The facility's Fire Response Plan last revised 03/08, indicated the employee shall dial 2-6666 and verbally state the specific location of the fire. The facilities Center PBX operator shall also contact the Clark County Fire department to notify them of an alarm activation. Severity: 3 Scope: 1 Complaint #NV00021515	S 297	**Individuals responsible: Director of Surgical Services, Director of Ancillary Services, Risk Manager, Performance Improvement Manager** **Date of Completion: August 30, 2009** Ensure Chloraprep solution used according to manufacturer's guidelines. New process for prepping in the Cardiac Cath Lab: 1. Chux will be removed after patient is prepped. 2. Sterile towels will be placed adjacent to patient in area of prep to catch prep run off and removed after prep and prior to draping. 3. 3 soaked sterile towels to be kept at back of surgical scrub table, to be used to extinguish any fire 4. Basin of sterile water to be kept on back of surgical scrub table, to be used to extinguish any fire 5. Prep time and 3 minute timer prompt added to MAC lab throughout the Valley Health System. 6. Review of prep solutions to be completed with assistance of Infection Control practitioner	
S 298 SS=G	NAC 449.361 Nursing Service 9. A hospital shall ensure that its patients receive proper treatment and care provided by its nursing	S 298	**Individuals responsible: Director of Surgical Services, Infection Control Coordinator** **Date of Completion: June 30, 2009**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 298	Continued From page 11 services in accordance with nationally recognized standards of practice and physicians' orders. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure a patient received proper treatment and care by its nursing service in accordance with nationally recognized standards of practice. (Patient #4) Finding include: A facility Physician Transfer Summary dated 03/21/09 indicated Patient #4 was a 90 year old female admitted to the facility with diagnoses including symptomatic bradycardia (low heart rate) hypertension and dementia. The patient was taken to the cardiac catheterization lab to have a pacemaker implantation. The pacemaker implantation was complicated by an intraoperative fire in the cath lab. The patient suffered significant facial and neck burns and was transferred to another Hospital Intensive Care Burn Unit for treatment. On 04/30/09 at 9:00 AM, the Chief Nurse indicated on 03/22/09 at approximately 7:00 PM, Patient #4 was in the cardiac catheterization suite lab for placement of a permanent pacemaker. The Chief Nurse indicated a Chlora Prep alcohol based prep was used on the patient's skin and allowed to dry for 20 to 30 minutes prior to the procedure started. The patient was on high flow oxygen re-breather mask. When the surgeon activated the Bovie Knife there was an arch that was witnessed by the surgeon and staff present and the patients drape expanded and caught on fire. The cardiologist removed the patients drape. The fire was extinguished by the tech that used a	S 298	**Tag S 298** The identified patient had been transferred to another facility prior to the survey and it is not possible to address this individual patient. All patients admitted to the facility have the potential to be affected by this practice. The Chief Nurse Officer reviews and authorizes all policies, procedures and standards of care related to nursing care, the facility also has a dedicated Policy and Procedure committee comprised of a multidisciplinary group and whose membership include Clinical Nurse Specialists who drive the evidence based practice and current national standards of care based on research of best practice. All employees are responsible for knowledge of facility policies and procedures and ensuring that their practice is consistent with those evidence based standards of care. **Individuals responsible:** **Chief Nursing Officer, Director of Surgical Services, Director of Ancillary Services, Risk Manager, Performance Improvement Manager** **Date of Completion: June 30, 2009**	

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S 298	Continued From page 12 bulb syringe with sterile water to extinguish the fire and a wet towel. The patient sustained second and third degree burns on her neck, face, chest, left shoulder and back. The emergency room physician was called and responded to the scene and assessed the patients airway and cleaned the patients burns. The patient was then transported to another facility's burn unit. The Chief Nurse did not recall if the fire department was notified. The incident was reported to the State Health Division on 03/26/09 at 11:30 AM. A Sentinel Event report was completed and submitted to the Nevada State Health Division by the facility on 04/07/09 at 12:30 PM. The Chief Nurse indicated the facility was looking at using non alcohol preps and revising the fire risk prevention procedure to include not allowing prep solution to pool under the patient and not draping the patient until the prep solution has dried. The Chief Nurse reported the facility's investigation indicated there were three factors that contributed to the incident. 1. The patient was on high flow oxygen with a re-breather mask. There was no oxygen tank in the cath lab. All oxygen was dispensed from an oxygen wall outlet. 2. The facility used Chlora Prep which was alcohol based prep and highly flammable. The recommended drying time was 3 minutes. The staff allowed the prep to dry for 20 to 30 minutes prior to starting the procedure. 3. Chux pads placed under the patient to catch any drip from the prep were not removed prior to the procedure and residual alcohol based Chlora Prep still present on the Chux pads may have been a fuel source and a contributing factor to the fire. When the surgeon activated a cautery tool	S 298		

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S 298	Continued From page 13 for hemostasis the drape covering the patient ignited burning the patient. On 04/30/09 at 11:00 AM, Employee #1 indicated she was responsible for applying the Chlora Prep to the patient prior to the placement of a permanent pacemaker battery procedure. Employee #1 indicated a thick.blue Chux pads was placed under the patients head and shoulder area prior to the administration of the prep solution to the patient's chest. Employee #1 indicated a 26 ml (milliliter) Chlora prep was used on the patients chest. Employee #1 could not recall how much of the prep solution may have dripped onto the Chux pads under the patient. The Chux pad was not removed from under the patient following the administration of the prep solution. The patient had a non re-breathable oxygen mask on and oxygen was flowing to the mask. A drape was placed on the patient which covered her face, oxygen mask and head in a tent like fashion. Employee #1 indicated the prep had dried for 15 to 20 minutes prior to the start of the procedure. Employee #1 left the cath lab and was not present when the procedure started. Employee #1 heard the patient scream and looked through the cath lab window and saw the surgeon pulling off the patients drape which was on fire. When employee #1 entered the cath lab with two blankets she saw the patients chest smoldering and the drape was on fire on the floor. The surgical technician had thrown a bowel of sterile water on the patient and used a sterile wet towel to put out the fire. Employee #1 acknowledged no one called a 6666 code red (fire alarm). Employee #1 did not know if any staff member called the fire department. Employee #1 indicated the facility no longer places chucks under the patients prior to using Chlora Prep. The facility now uses a washcloth or towel and	S 298		

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S 298	Continued From page 14 removes them when the prep is completed. On 04/30/09 at 1:00 PM, Employee #2 indicated prior to the placement of a permanent pacemaker battery procedure a Chux pad was placed under the patients head and shoulders and Chlora Prep was used to prep the patient's chest area. The patient was receiving 10 liters of oxygen via a non rebreathe mask. The Chux pad was left under the patient and the patient was then draped after the prep on the patient's chest had dried. Employee #2 indicated she saw the surgeon use cautery tool on the patients chest and saw the drape covering the patients head catch on fire. The surgeon removed the drape and the patient's chest was on fire. The fire was extinguished by the surgical technician who used a basin of sterile water to douse the flames. Employee #2 indicated she did not follow the facility's fire response plan and call a code red when the fire occurred. Employee #2 confirmed the fire department did not show up at the facility or conduct an investigation into the cause of the fire. Employee #2 indicated she had been working in the cath lab for 7 years as a scrub monitor and circulating nurse but had not been trained by the facility on the use of alcohol based preps or the potential risk of flammable vapors igniting and causing injury to a patient. The Sentinel Even Report- Section II dated 04/07/09 at 12:30 PM, under Primary Contributing Factors indicated the following: "The incident was staff related/clinical performance/administration. The corrective action included equipment modification, policy review, procedure review, process review, situation analysis and staff education and training."	S 298		

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S 298	Continued From page 15 Chlora Prep drug facts indicated the active ingredients consisted of Chlorhexidine Gluconate 2% (Antiseptic) and Isopropyl Alcohol 70% (Antiseptic) Warnings Included: "For external use only. Flammable, keep away from fire or flame. To reduce risks of fire: a. "Solution contains alcohol and gives off flammable vapors." b."Do not drape or use ignition source (cautery, laser) until solution is completely dry" (minimum of 3 minutes on hairless skin) c."Avoid getting solution into hairy areas. Solution may take much longer to dry completely." d."Do not allow solution to pool." e."Remove wet materials from prep area." Directions: 1. "To reduce the risk of fire the following strategies are recommended." a. "At the end of the prep, discard any portion of the solution which is not required to cover the prep area." b. "Use in a well ventilated area." c. "Tuck prep towels to absorb solution, then remove." d. "Remove wet material from prep area." e. "Drape after solution is completely dry." The facility's Surgical Skin Prep Washing/Painting policy and procedure dated 08/06 included the following: 1. "Keep the prep solution from pooling beneath the patient and away from the electrosurgical patient electrode and tourniquets. Chemical burns may result if allowed to remain in contact	S 298		

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S 298	Continued From page 16 with the skin." 2. "Sufficient time for complete evaporation of a flammable antimicrobial agent needs to occur before electrosurgical devices or lasers are used. Evaporation of flammable antimicrobial agents decreases the possibility of fire." "Open towel and pat dry the area dry to remove excess scrub solution. Remove the towels used to square off the field by lifting edges of the towel while paying close attention not to drag edges of towel across prepped field." The facility's AORN (Association of Peri Operative Registered Nurses) Fire Safety Tool Kit Policy last revised 1/05 included the following: 1."When an alcohol based solution is used, use minimum amount of the solution and allow sufficient time for fumes to dissipate before draping." 2."Observe drying time (minimum 3 minutes) do not drape patient until flammable prep is fully dry." 3."Do not allow pooling of any prep solution." (including under patient) 4."Remove bowls of volatile solution from sterile field as soon as possible after use." 5."Utilize standard draping procedure." Severity: 3 Scope: 1 Complaint #NV00021515	S 298		
S 310 SS=D	NAC 449.3624 Assessment of Patient 1. To provide a patient with the appropriate care at the time that the care is needed, the needs of	S 310		

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S 310	Continued From page 17 the patient must be assessed continually by qualified hospital personnel throughout the patient's contact with the hospital. The assessment must be comprehensive and accurate as related to the condition of the patient. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to provide a patient with appropriate care and continually assess the patients condition throughout the patients contact with the hospital. (Patient # 6) Findings include: A History and Physical dated 07/28/08, indicated the Patient #6 was a 75 year old female admitted to the facility on 07/07/08, with a diagnosis of malignant hypertension secondary to bilateral renal artery stenosis and severe chronic obstructive pulmonary disease. The patient had aorto-birenal and aortofemoral bypass graft surgery. The patient had weakness and paresis of both legs post surgery. The Patient Care Assessment Record dated 07/07/08 at 8:00 PM, indicated the patients integumentary system was within normal limits. There was no documentation of skin breakdown. The Patient Care Assessment Record and Pressure Ulcer record dated 07/17/08, indicated the patient developed an unstagable coccyx ulcer. The Patient Care Assessment Record and Pressure Ulcer record dated 07/28/08, indicated the patient developed a stage 1 to stage 2 sacral ulcer. The patient was treated with Xenaderm Cream twice a day with dressing and Silvadine	S 310	**Tag S 310** The identified patient had been discharged prior to the survey and it is not possible to address this particular patient. All patients admitted to the facility have the potential to be affected by this practice. The Director/Manager of the unit involved with this individual patient has reviewed the policies and procedures related to admission assessment and documentation of that assessment and the ongoing assessment that is to be completed and documented every twelve hours. The facility has a Wound and Skin Care Nurse specialist and a MEC approved Skin Care Protocol. The facility conducts a wound and skin incidence and prevalence study, the study completed in January 2009 showed the rate of incidence as 2%. The Director/Managers of the units involved with the care of this individual patient have reviewed the policies and procedures with their clinical staff. Individual staff were also counseled following a medical record review. The facility has also formed a RISC (Resource In Skin Care) team to act as resources for clinical staff when caring for a patient with a decubitus,	

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S 310	Continued From page 18 application. On 05/01/09 at 3:50 PM, Patient #6's medical record was reviewed with the Director of Quality Improvement. The Director confirmed it was the facility's policy to initiate a wound care protocol on patients who had a potential to develop decubitus ulcers or who presented to the facility with skin breakdown. The wound care protocol included keeping the patients skin clean and dry, managing incontinence, repositioning the patient every 2 hours, applying moisturizing cream when needed, and the use of protective devices for heels and elbows. The Director confirmed there was no documented evidence of a wound care protocol in the patients medical record. The Director acknowledged there was no indication the nurses initiated a wound care protocol or documented the condition of the patients sacral decubitus ulcer on a consistent basis. A Rehabilitation Hospital Admission History and Physical dated 07/29/08, indicated due to prolonged bedrest at the facility the patient developed a sacral decubitus ulcer. Wound care was consulted for evaluation. Sacral Decubitus Ulcer: The patient had a 5 cm x 5 cm (centimeter) sacral wound that was necrotic with fibrotic tissue. The wound was unstageable. The wound had moderate to heavy drainage. Surrounding the wound was a large 20 x 20, stage 1 as well as stage 2 decubitus ulcer, with erythema and raw tissue, with tenderness upon palpation. The wound had a moderate amount of drainage. The facility's Skin Assessment and Pressure Ulcer Wound Care Protocol indicated the facility used the Braden Scale for predicting pressure sore risk. The Braden Scale consisted of the following categories:	S 310	**Individuals responsible: Director/Manager of Medical/Surgical Units, Director/Manager of Critical Care, Wound Care Coordinator** **Date of Completion: June 30, 2009**	

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S 310	Continued From page 19 1. Sensory Perception 2. Moisture 3. Activity 4. mobility 5. Nutrition 6. Friction and Shear. The nurses were to complete the Braden Scale Score daily during daylight skin assessment and identify high risk patients for pressure ulcers. Upon identification of a pressure ulcers nurses were to initiate the Pressure Ulcer Monitoring Tool which included the following: Stage I: Non-blanchable redness of intact skin. 1. "Provide pressure relief by repositioning every one to two hours. Use pressure relieving devices, such as, pressure reduction boots, bed wedges, and/or pillows." 2. "Protect the skin from incontinence through the use of moisturizing cream. Apply frequently and after each episode of incontinence." 3. "Document the skin assessment every shift." Stage II: Partial thickness skin loss involving epidermis or dermis, or both. 1. "Obtain consent for photo of wound using light block. Document the patients name, date and time on the photo." 2. "Measure and document the size in centimeters and appearance of wound bed and surrounding tissue." 3. "Clean with Normal Saline. Apply No-Sting	S 310		

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S 310	Continued From page 20 Skin Prep to the surrounding intact skin." 4. "Apply Duoderm thin (hydrocolloid), label and date and change every 3 days."If draining, apply Allevyn foam adhesive or Allevyn foam, window paned with hypafix tape. Date dressing and change every 3 days. measure and document with each dressing change." 5. "Reposition every 2 hours." The facility's Pressure Ulcer care Policy dated 06/08, included the following: 1. "Institute the Pressure Ulcer Wound Care Protocol on all patients who have been identified as having a pressure ulcer." 2. "Obtain and initiate standing pressure ulcer wound care orders for a stage II or greater pressure ulcer." 3 "The wound and skin nurse is available for skin care consultation and may be called by any member of the team after a physician's order has been received." On 05/01/09 at 3:50 PM, a review of Patient # 6's medical record revealed no documented evidence the nursing staff initiated a Pressure Ulcer Wound Care Protocol or Pressure Ulcer Monitoring Tool for the patient. Severity: 2 Scope: 1 Complaint #NV00018985	S 310		
S 322 SS=D	NAC 449.3628 Protection of Patients 2. The governing body shall develop and carry	S 322		

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S 322	Continued From page 21 out policies and procedures that prevent and prohibit neglect and misappropriation of the personal property of a patient. This Regulation is not met as evidenced by: Based on record review and document review the facility failed to carry out policies and procedures to prevent the neglect of personnel property of a patient. (Patient #3) Findings include: On 04/21/08 a report from the Division of Aging Services indicated Patient #3 was discharged home from the facility on 04/18/08, with no clothing or belongings and wrapped only in a blanket. Emergency Room Nursing record dated 04/17/08, indicated the patient was brought to the emergency room by ambulance from home. The patient was disrobed at 6:45 AM and placed in a gown. A facility Exit Care Patient Information form dated 04/18/08 at 7:30 PM, revealed the only discharge instruction documented on the form was for the patient to follow-up with her primary care physician in 1 week. A Nursing Note dated 04/18/08 at 7:30 PM indicated the patient was discharged home via a medi coach via a stretcher. On 04/30/09 at 8:00 AM, a review of the medical record indicated there was no documentation of a completed patient belongings form filled out by	S 322	**Tag S 322** The identified patient had been discharged prior to the survey and it is not possible to address this particular patient. All patients admitted to the facility have the potential to be affected by this practice. The policy and procedure has been reviewed, no revisions were required. The Director/Manager of the unit involved with this individual patient has reviewed the policies and procedures related to the documentation and care of patient's personal effects and valuables with her staff. Additionally this information was reviewed by Directors/Managers of all clinical and ancillary departments The facility policy states that a Belongings Inventory must be completed at time of admission. Patients are encouraged to send home valuables with family members or have the valuables locked in the security safe. The facility has developed a Hands Off Communication tool, "*The Ticket to Ride*". The tool is for all patients admitted via the Emergency Department and transferred within the facility and one of the issues addressed is belongings. **Individuals responsible: Director/Manager of Medical/Surgical Units, Director/Manager of Critical Care, Director of Ancillary Departments** **Date of Completion: June 30, 2009**	

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S 322	Continued From page 22 the facility when the patient was admitted and no documentation of belongings returned to the patient upon discharge. On 05/01/09 at 8:30 AM, the Performance Improvement Manager reviewed Patient #3's medical record and confirmed there was no documented evidence of a patients belonging form. The Performance Improvement Manager indicated the nursing staff failed to follow the facility's Personal Effects and Valuables Policy by not documenting the patient's valuables and personal effects on the Patient Personal Effects and Valuables form upon admission to the facility. A facility Nurses Discharge Notes and Instruction Policy dated 05/07, indicated under Procedure: Patient Instructions should include: a. A completed medication reconciliation. b. How to meet the needs for physical, emotional pain management. c. Available community resources. d. The nurse will document what the physician ordered for follow-up care. e. The nurse will instruct the patient on activity level, diet, equipment needed f. The nurse will check those items instructed to the patient. g. The nurse will document whether the patient verbalizes understanding of the instructions by checking the yes or no box. h. The nurse will document the valuables returned and personal belongings by checking the yes or no box. The facility's Safe Care of Patient's Personal Effects and Valuables Policy dated 09/08, included the following:	S 322		

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S 322	Continued From page 23 "The Patient Personal Effects and Valuables Checklist must be filled out upon admission by nursing personnel, and signed by the patient or next of kin. The Patient Personal Effects and Valuables Checklist filled out in the ED (emergency department) will be kept in the patient's medical record, filed under Miscellaneous. Patient valuables and property shall be returned only to the patient." Severity: 2 Scope: 1 Complaint #NV00018051	S 322		
S 335 SS=D	NAC 449.363 Personel Policies 1. A hospital shall have written policies concerning the qualifications, responsibilities and conditions of employment for each type of hospital personnel, including the licensure and certification of each employee when required by law. This Regulation is not met as evidenced by: Based on interview and document review the facility failed to ensure policies concerning employment, licensure and certification of a physician were followed when required by law. Findings include: A letter from the Nevada State Board of Medical Examiners dated 04/13/09 indicated Physician #1's privileges were suspended at the facility on 02/06/09. The Board of Medical Examiners received notice of the physician's suspension from the facility on 04/01/09. NRS 630.307 (2) included any hospital, clinic or other medical facility licensed in this State, or medical society, shall report to the Board any	S 335	**Tag S 335** The facility failed to notify the Nevada Board of Medical Examiner within the 30 day timeframe dictated by Nevada law. There was confusion regarding when the time period for reporting started, this physician had his privileges re-instated and then resigned while still under investigation, so staff was unsure of which date started the timeline for reporting. The Medical Staff Manager and staff were counseled and have been re-educated on the Nevada Statutes and understand how and when to report any disciplinary action taken against a physician. **Individual Responsible:** **Medical Staff Manager, Performance Improvement Manager, Risk Manager** **Date Completed: May 1, 2009**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS641HOS	A. BUILDING _____ B. WING _____	05/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT SPRINGS HOSPITAL	2075 EAST FLAMINGO ROAD LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 335	Continued From page 24 change in a physician's privileges to practice medicine while the physician is under investigation and the outcome of any disciplinary action taken by the facility against the physician concerning the care of a patient or the competency of the physician within 30 days after the change in privileges is made or disciplinary action is taken. On 04/30/09 at 10:00 AM, the Manager of Medical Staff Services indicated the facility used NRS 630.307 (2) as policy in regards to reporting a suspension of a physician's privilege to practice at the facility. The Manager of Medical Staff Services indicated Physician #1's privileges to practice at the facility was suspended on 02/06/09 due to disruptive conduct that caused a distraction to a surgeon and clinical and supportive staff which represented a probability of danger to a patient. Physician #1 met with the facility's Medical Executive Committee on 02/18/09, and the Medical Executive Committee agreed to lift the physician's summary suspension upon the physician's agreement to abide by the facility's Privilege Retention Conditions which included the following: a. Physician report to the Nevada Physicians Health Program for issues related to anger management and that he must comply with the conditions imposed by the NPHP (Nevada Physicians Health Program) based upon the outcome of an evaluation; comply with the Hospitals Bylaws. b. Conduct himself in a professional manner c. Fully refrain from any form or type of conduct which is indicative of disruptive behavior including but not limited to, unprofessional interactions and verbal or physical displays of anger or lack of sensitivity for patient and staff.	S 335		

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S 335	Continued From page 25 d. Comply with the terms and conditions of the Bylaws or MEC; (Medical Executive Committee) e. Comply with the recommendations of the NPHP. The Manager of Medical Staff Services indicated Physician #1 agreed to the Privilege Retention Conditions and the summary suspension was lifted and his medical staff membership and clinical privileges were reinstated effective 03/03/09. Physician #1 resigned from the facility on 03/26/09. The Manager of the Medical Staff Office acknowledged there was a delay in sending a notification of suspension of privileges for Physician #1 to the Board of Medical Examiners and confirmed the letter was sent on 03/26/09 which was 48 days after his suspension. The manager acknowledged the notification of suspension should have been made within 30 days per the facility's policy and NRS 630.307 (2). A copy of a Special Notice of Summary Suspension dated 06/06/09, and addressed to Physician #1 indicated the Medical Executive Board of the facility had summarily suspended the physician's medical staff membership effective 02/06/09. A copy of a Proposal for Termination of Summary Suspension dated 02/19/09, and addressed to Physician #1 indicated the Medical Executive Board, after meeting and reviewing the issues surrounding the suspension had recommended the summary suspension be terminated provided the physician complied with conditions of a Privilege Retention Agreement. A copy of a letter sent by the facility to the State Board of Medical Examiners dated 03/26/09, indicated Physician #1's privileges were	S 335		

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S 335	Continued From page 26 summarily suspended at the facility on 02/06/09 for patient safety issues and the suspension was subsequently lifted on 03/03/09. Severity: 2 Scope: 1 Complaint #NV00021612	S 335		